Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
NUEVA VIDA BEHAVIORAL HEALTH

Respondent Name
VIA METROPOLITAN TRANSIT

MFDR Tracking Number
M4-14-3353-01

Carrier's Austin Representative
Box Number 16

MFDR Date Received
July 7, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The CPT code billed for the date of service 3/7/14 was 99080. The code is described as : *Special reports such as insurance forms, more that [sic] the information conveyed in the usual medical communications or standard reporting form.* We were paid $1.00, the actual reimbursement should have been $100.00

Amount in Dispute: $100.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "According to the documentation from the provider dated April 8, 2014, the narrative report was written as an appeal regarding a denied-pre-authorization request. Since this response was not requested by the employer/insurance carrier or the Division, no reimbursement is due. This explanation was provided to Nueva Vida Behavioral Health in the comment section of the explanation of benefits-see enclosure."

Response Submitted by: Argus Service Corporation

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 7, 2014	99080	$100.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets out the general Medical Dispute Resolution guidelines.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedure for Medical Dispute Resolution of Medical Necessity Disputes.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1A – Workers Compensation State Fee Schedule adjustment 'Reimbursement per Rule 134.202/134.204. Prior to March 1, 2008, Rule 134.202.
   - Note: Narrative reports are defined as documents created at the written request of the insurance carrier or the division.
   - W3W – No reimbursement recommended on reconsideration. Previous recommendation was in accordance with the Workers' Compensation State Fee Schedule.
   - 50 – These are non-covered services because this is not deemed a medical necessity by the payer.

Issues

1. Did the medical fee dispute referenced above contain information/documentation that indicates that there are **unresolved** issues of medical necessity?
2. What is the dispute process for resolving medical necessity denials?
3. What is the dispute sequence?
4. What are the filing requirements after the resolution of a medical necessity denial?
5. Are the disputed services eligible for review by Medical Fee Dispute Resolution?

Findings

1. The medical fee dispute referenced above contains information/documentation that indicates that there are **unresolved** issues of medical necessity for the same service(s) for which there is a medical fee dispute. Review of the EOBs presented by the both the requestor and respondent indicate denial reason code "50 – These are non-covered services because this is not deemed a medical necessity by the payer."
2. **Resolution of a Medical Necessity Dispute.** The Division hereby notifies the requestor the appropriate process for resolution of an unresolved issue of medical necessity requires filing for an independent review to be conducted by an IRO (independent review organization) appropriately licensed by the Texas Department of Insurance, pursuant to 28 Texas Administrative Code §133.308. Information applicable to HEALTH CARE PROVIDERS on how to file for an IRO may be found at http://www.tdi.texas.gov/hmo/iro_requests.html under ***Health Care Providers or their authorized representatives.***
3. **Notice of Dispute Sequence.** 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding…medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding…medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021.
4. The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code §133.307. 28 Texas Administrative Code §133.307 (c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals.
5. The division finds that due to the unresolved medical necessity issues, the medical fee dispute request is not eligible for review until a final decision has been issued in accordance with 28 Texas Administrative Code §133.308.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 18, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.